BEFORE THE ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

IN THE MATTER OF: **MONIKA DURGIN, DVM** HOLDER OF LICENSE NO. 1968 FOR THE PRACTICE OF VETERINARY MEDICINE IN THE STATE OF ARIZONA, **RESPONDENT.**	**CASE NO.: 22-33** **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**

The Arizona State Veterinary Medical Examining Board ("Board") considered this matter at its public meeting on May 18, 2022. Monika Durgin, DVM ("Respondent") appeared on her own behalf for an Informal Interview that was held pursuant to the authority vested in the Board by A.R.S. § 32-2234(A) and was represented by attorney David Stoll, Esq. After due consideration of the evidence, the arguments and the applicable law, the Board voted to issue the following Findings of Fact, Conclusions of Law and Order ("Order").

FINDINGS OF FACT

1. Respondent is the holder of License No. 1968 and is therefore authorized to practice the profession of veterinary medicine in the State of Arizona.

2. On August 17, 2021, at approximately 7:15am, an approximately 1.5 year-old male French Bull dog ("Patient") was presented to Respondent for a neuter procedure. Upon exam, the Patient had a weight = 21.4 pounds, a temperature = 99.9 degrees, a heart rate = 150bpm, and a respiration rate = panting. Respondent did not evaluate the Patient's oral/nasal/throat according to the medical record – the only systems that were noted to be

evaluated were the Patient's eyes, ears, cardiovascular and respiratory – all marked normal. However, according to Respondent she noted the Patient had marked stenotic nares and offered to do the nares widening procedure while the Patient was being neutered; the pet owner, Complainant's girlfriend, agreed. An estimate was provided. Respondent did not document in the medical record that the pet owner approved to have the nares widened as well as the neuter. However, the abbreviation "SN" was noted on the authorization form.

3. Later that day, at approximately 1:55 p.m., the Patient was administered TTDex 0.21mLs IM. The cocktail amount of each medication and their concentrations were not documented in the medical record. In addition, the medical record states that TTDex was administered at 2:35 p.m. Respondent provided the TTDex dispensing log which shows the medication amounts and concentration as follows: 2.5mL 10mg/mL butorphanol + 2.5mL 0.5mg/mL dexmedetomidine + 5mL Telazol cake.

4. The Patient was monitored in his kennel until he was ready to be intubated. A member of the office staff removed the Patient from the kennel, placed him on the surgery table, and began placing the endotracheal tube. Within seconds of placing the Patient on his back, the same staff member called for assistance due to the Patient becoming cyanotic despite being intubated. Staff was unable to locate a heartbeat; therefore, Respondent was alerted. The Patient was administered the following while chest compressions were being conducted:

a. Antisedan 0.11mL IM;

b. Epinephrine 1mL IV; and

c. Epinephrine 1mL IC.

5. Also, while CPR was being performed, the pet owner was contacted and instructed to come to the premises as the Patient had arrested. Respondent reported that when the pet owner arrived with Complainant, the Patient had passed away.

6. Respondent spoke with the pet owner. She offered cremation, taking the Patient's remains home, or a necropsy. The pet owner chose to have the Patient cremated at Respondent's expense and a paw print was made.

7. Respondent stated in her response to the complaint that she updated the neuter notes to be CPR notes; therefore, the time the note was made did not reflect the time the drugs were administered – the time the medications were administered were noted in the body of the CPR notes. Staff also updated the Patient's chart; therefore, the time the anesthesia was administered could not be changed to reflect the actual time of administration. This was the same for staff documenting conversations that took place with the pet owners and the time stamp in the medical record not being the accurate time they spoke with the pet owners.

8. The Board concluded that Respondent deviated from the standard of care when she administered a high dose rate of TTDex to a high-risk breed. Doing so resulted in the Patient going into respiratory depression and eventual death. The Board also concluded that knowing the dog was a high-risk brachycephalic breed, Respondent deviated from the standard after the Patient was administered the TTDex by not ensuring that he was closely monitored.

9. A veterinarian is required maintain a written medical record reflecting the services the animal received and containing, at a minimum, the results of the examination, the concentration of the medications administered, and an accurate recording of when the medications were administered.

CONCLUSIONS OF LAW

10. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (11)** Gross negligence[1]; for failure to be aware of the proper dose of TTDex for a compromised animal that was administered to the Patient, which led to respiratory depression and eventually death; and not properly monitoring the Patient prior to surgery.

11. The conduct and circumstances described in the Findings of Fact above, constitutes a violation of **A.R.S. § 32-2232 (21)** as it relates to **A.A.C. R3-11-502 (L) (4)** failure to ensure the Patient was examined, or the exam was documented in the medical record, and ensuring timed entries documented into the medical record were accurate.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law it is **ORDERED** that Respondent's License, No. 3703 be placed on **PROBATION** for a period of one (1) year, subject to the following terms and conditions that shall be completed within the Probationary period. These requirements include eight (8) total hours of continuing education (CE) detailed below:

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[1] A.R.S. § 32-2201(9) defines "gross negligence" as the treatment of a patient or practice of veterinary medicine resulting in injury, unnecessary suffering or death that was caused by the carelessness, negligence or the disregard of established principles or practices.

1. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed five (5) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these five (5) hours by attending CE in the area of anesthesia. Respondent shall submit written verification of attendance to the Board for approval.

2. **IT IS ORDERED THAT** Respondent shall provide written proof satisfactory to the Board that she has completed three (3) hours of continuing education (CE); hours earned in compliance with this order shall not be used for licensure renewal. Respondent shall satisfy these three (3) hours by attending CE in the area of medical record keeping. Respondent shall submit written verification of attendance to the Board for approval.

3. **IT IS ORDERED THAT** Respondent shall pay a civil penalty of five hundred dollars ($500) on or before the end of the Probation period. Civil penalty shall be made payable to the Arizona State Veterinary Medical Examining Board and is to be paid by **cashier's check** or **money order**.

4. **All continuing education to be completed for this Order shall be pre-approved by the Board**. Respondent shall submit to the Board a written outline regarding how she plans to satisfy the requirements in paragraph 1 and 2 for its approval within sixty (60) days of the effective date of this Order. The outline shall include **CE course details** including, **name, provider, date(s), hours of CE** to be earned, and a **brief course summary**.

5. Respondent shall obey all federal, state and local laws/rules governing the practice of veterinary medicine in this state.

6. Respondent shall bear all costs of complying with this Order.

7. This Order is conclusive evidence of the matters described and may be considered by the Board in determining an appropriate sanction in the event a subsequent violation occurs. In the event Respondent violates any term of this Order, the Board may, after opportunity for Informal Interview or Formal Hearing, take any other appropriate disciplinary action authorized by law, including suspension or revocation of Respondent's license.

NOTICE OF APPEAL RIGHTS

Respondent is hereby notified that she has the right to request a rehearing or review of the Order by filing a motion with the Board's Executive Director within 30 days after service of this Order. Service of the Order is effective five days after the date of mailing to Respondent. *See* A.R.S. § 41-1092.09. The motion must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R3-11-904. If a motion for rehearing or review is not filed, the Board's Order becomes final 35 days after it is mailed to Respondent. Respondent is further notified that failure to file a motion for rehearing or review has the effect of prohibiting judicial review of the Order, according to A.R.S. § 41-1092.09(B) and A.R.S. § 12-904, et seq.

Dated this 27th day of June, 2022.

Arizona State Veterinary Medical Examining Board
Jim Loughead
Chairman

By: Victoria Whitmore
Victoria Whitmore, Executive Director

Original of the foregoing filed this 27th day of June, 2022 with the:

Arizona State Veterinary
Medical Examining Board
1740 W. Adams St., Ste. 4600
Phoenix, Arizona 85007

Copy of the foregoing sent by certified, return receipt mail this 27th day of June, 2022 to:

Monika Durgin, DVM
Address on file
Respondent

this 27th day of June, 2022 to:

David Stoll, Esq.
Beaugureau, Hancock, Stoll and Schwartz, PC
302 E. Coronado Rd
Phoenix, Arizona 85004

By: V. Whitmore
Board Staff